Liberty Speech Associates

Welcome to Liberty Speech Associates LLC! Thank you for selecting our office for your speech and language needs. Our goal is to provide you and your family with quality, research-based speech-language pathology services. We strive to promote the effective and functional communication skills of our clients.

Enclosed in this packet, you will find the following forms:
- Adult Intake Form
- Policies and Procedures
- Communication Preference Form
- Insurance Form
- Acknowledgement of HIPAA Privacy Notice
- HIPAA Policy

If you have any questions, please feel free to contact us by phone or email. We are looking forward to working with you.

Please sign below to acknowledge the following:

-You have read all of the forms and documents provided to you in connection with evaluation and treatment provided by Liberty Speech Associates LLC, their employees, and/or contractors.

-You understand the meaning and intent of the provided forms and agree to all content included.

-You have been given an opportunity to ask questions about the provided forms and all questions you've asked have been answered to your satisfaction by Liberty Speech Associates LLC.

_____ _____

Name of Client* Today's Date*

_____

Signature of Client or Legal Representative*

_____ _____

Name of Legal Representative* Relationship to Client*

Adult Intake Form

Name of Person Completing This Form: _____

Relationship to Client: _____

Name of Client: _____

Date of Birth: _____ Age: _____ Sex: Male ▢ Female ▢

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail: _____

Language(s) Spoken: _____

Is English your primary language? ▢ Yes ▢No

If no, is an interpreter needed? ▢ Yes ▢No

Emergency Contact:

Name: _____

Phone Number: _____

Is this number for: ▢ Home ▢ Cell ▢ Work

Relationship to Client: _____

Speech and Language Services:

Describe the reason for your visit:

_____

_____

_____

When did your symptoms begin? _____

Referral source:

▢ Doctor ▢School ▢Employer ▢Counselor/Therapist ▢Friend ▢Self ▢Other

If other, please describe:

_____

Have you received speech-language pathology services before? ▢ Yes ▢ No

If yes, describe when, where, and why services were received:

_____

_____

_____

Medical History:

Name of Primary Doctor:

_____

List all doctors/specialists involved in your care:

_____

_____

List illnesses, surgeries, injuries, or medical problems:

_____

_____

List medications taken on a regular basis:

_____

_____

List known allergies:

_____

_____

Do you wear hearing aid(s)? ▢ Yes ▢ No

If yes, please describe: _____

_____

Have you had a hearing test? ▢ Yes ▢ No

If yes, please describe: _____

_____

Do you wear glasses? ▢ Yes ▢ No

If yes, please describe: _____

_____

Do you wear eye contacts? ▢ Yes ▢ No

If yes, please describe: _____

_____

Has your vision been screened? ▢ Yes ▢ No

If yes, please describe: _____

_____

Do you have any dental problems? ▢ Yes ▢ No

If yes, please describe: _____

_____

Do you wear dentures? ▢ Yes ▢ No

If yes, please describe: _____

_____

Do you have difficulty breathing: ▢ Yes ▢ No

If yes, please describe: _____

_____

Do you have difficulty swallowing: ▢ Yes ▢ No

If yes, please describe: _____

_____

Work/Educational History:

Last grade completed or current grade if still in school: _____

Occupation: _____

Currently working? ▢ Yes ▢ No

What are some of your recreational activities: _____

_____

Additional Information:

If there is anything else that you would like to share, please include it below

_____

_____

By signing below, you agree to allow Liberty Speech Associates LLC, their employees, and/or their contractors to provide speech-language pathology services to you. You consent to all services that are within the scope of speech-language pathology practice as defined by the state of New Jersey and the American Speech-Language-Hearing Association. You acknowledge that no guarantee has been made to you as to the result of the evaluation and/or treatment.

_____ _____

Name of Client* Today's Date*

_____

Signature of Client or Legal Representative*

_____ _____

Name of Legal Representative* Relationship to Client*

Policies and Procedures Form

Please carefully review the policies and procedures outlined below:

Illness: It is not beneficial for you to attend in-person therapy or evaluations when you are ill or contagious. For that reason, in-person sessions should be canceled under the following circumstances:

- If you have had a fever, have been vomiting, or have had diarrhea in the past 24 hours,
- If you have a rash, and/or
- If anyone in the household has lice or flu-like symptoms.

If you are receiving teletherapy services, you can attend the appointment when you have the aforementioned illnesses, so long as you are well enough to participate in therapy/evaluation tasks. We will leave this up to your discretion.

Holiday Closings: Our office will be closed on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas Eve, Christmas Day, and New Year's Eve. Our office will also be closed the week between Christmas and New Year.

Weather: In the event of inclement weather, you will be notified prior to your appointment if the session is going to be canceled.

Payment: Payment for direct client contact is expected at the time of service. You will receive a bill in the mail for consultative services. Payment can be in the form of credit card, cash, or checks made payable to Liberty Speech Associates LLC. A $25 service charge will be required for any returned checks.

If you are using a third-party payer (e.g., insurance company, employer, etc.) for speech therapy and/or evaluation coverage, you understand that you are responsible for all costs / fees that the third-party payer does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, you will be responsible for all outstanding charges. You will be billed accordingly and will be responsible for immediate payment. Liberty Speech Associates LLC will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial. If fees are not paid in full, treatment sessions may be postponed or canceled until payment is received. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client’s expense. Overdue accounts may also be reported to a Credit Bureau. You are responsible for all legal and collection fees, which Liberty Speech Associates LLC may incur if payment is not made in accordance with the terms and conditions herein.

Refunds will be issued only in instances of overpayment. All refunds will be processed within 1 week after the overpayment is discovered on the client's bill or at the time the refund is requested.

Insurance:
In-Network: We are currently in-network with *Aetna* and *Medicare Part B*. If you have one of these insurances, we will submit claims on your behalf. Please be advised that in-network participation does not guarantee coverage for your speech and language services. You are responsible for any applicable copays, coinsurances, deductibles, and/or unpaid claims. Our in-network participation status may change at any time. You will be notified in advance of these changes.

Out-of-Network: We are considered out-of-network with any insurance not listed above. If you are a member of a non-participating insurance company, our office can supply you with a receipt detailing the services that were rendered so that you may submit it to your insurance company in an effort to obtain reimbursement. Please note that our rates may be different from your insurance reimbursement rate and reimbursement rates could be lower. Additionally, depending on your insurance coverage, you may not receive reimbursement for speech and language services. We recommend that you check with your insurance carrier for rates and coverage of services. If you are interested in receiving detailed receipts to submit to your insurance company, please notify our office.

Attendance: Attendance and participation in therapy, along with complete compliance with any associated home programs, are essential for therapeutic success. While we understand that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows."

Cancellation: Each client is entitled to 2 cancellations for any reason per quarter without penalty. Any additional cancellation must be made up within the same quarter that the cancellation occurred. If the make-up session is not completed within the required timeframe, you will be charged for the full session fee for the missed appointment (currently $130).
Initial* _____

Our office defines quarters as follows:

January 2 - March 31
April 1 - June 30
July 1 - September 30
October 1 - December 23

No Show: Our office defines a "no show" as an appointment that is canceled without notice, as well as a cancellation made within 30 minutes of the scheduled appointment time. You will be charged for the full session fee for the no show (currently $130).
Initial* _____

Please be advised that third-party payers do not cover cancellation or no show fees. If you cancel or do not attend 3 consecutive appointments, we will put your services on hold until scheduling problems can be worked out. Initial* _____

Late for Appointments: You must be present and available to start the speech therapy session and/or evaluation at your scheduled appointment time. The speech-language pathologist will wait up to 10 minutes for you to be available, so that the appointment can begin. If you are up to 10 minutes late for your appointment, we will deduct that time from the allotted session time (e.g., If you are scheduled for a 30-minute session to begin at 10:00 am, but you are late and the session does not begin until 10:10 am, you will only receive a 20-minute session that day). Please be aware that if the appointment begins late because you were not present or available, you will still be billed the cost of a complete appointment. If you are late for 3 or more sessions, we may put your services on hold until scheduling problems can be worked out. If you are more than 10 minutes late for your appointment, we reserve the right to cancel the appointment and consider it a no show. As stated above, a no show incurs a full session charge (currently $130).
Initial* _____

Clinician Cancellations: If your speech-language pathologist is not able to attend your appointment (due to illness, emergency, etc.), you will be contacted as soon as possible. You will be given advance notice of the speech-language pathologist's vacations. Please be sure that your speech-language pathologist knows the best way to reach you.

Services:

Therapy

Therapy sessions vary in length depending on the client's needs. The last few minutes of each session will be spent discussing the session with you and/or relevant others, providing home practice activities, and writing notes about treatment. If you require additional time to discuss your treatment outside of the scheduled therapy appointment, please contact our office to schedule a phone consultation or in-person conference. The consultation/conference will be billed at $100/hour (prorated).

Evaluations

Evaluation appointments vary in length depending on the client's needs. The anticipated length of the appointment time will be discussed prior to the initiation of the appointment. After the evaluation has been completed, you will receive a diagnostic report detailing your

performance during the evaluation, as well as relevant recommendations. If you need additional time to discuss your evaluation beyond the scheduled appointment period, please contact our office to schedule a phone consultation or in-person conference. The consultation/conference will be billed at $100/hour (prorated).

Privacy and Confidentiality: We respect your privacy and confidentiality. Email, text messages, and direct messages on Facebook and other social media platforms are insecure methods of transmitting and discussing confidential information. If you would like to discuss your treatment or evaluation, it is best that you schedule a phone consultation or in-person conference. Treatment or evaluation results can be discussed with relevant others (e.g., family member, healthcare professional) upon request. If you would like us to discuss or share your treatment or evaluation results with a family member, agency, or professional, please complete an Authorization to Exchange Information.

Termination of Services: You may terminate your therapy by phone, email, or in person at any time for any reason.

Changes in Policy: Changes to this policy may be made at any time. You will be notified of any policy changes before they take effect.

▢ I agree to the policies and procedures outlined above.*

_____ _____

Name of Client* Today's Date*

_____

Signature of Client or Legal Representative*

_____ _____

Name of Legal Representative* Relationship to Client*

Communication Preference Form

Primary Contact Person:* _____

Relationship to Client:* _____

Home Phone: _____

Work Phone: _____

Cell Phone:* _____

Email: _____

In an effort to ensure your privacy, it is important for us to understand your preferred contact method(s). As such, please indicate your communication preferences below.

Clinical Information

For clinical information, such as clinical documentation, diagnostic reports, therapy updates, etc., I hereby grant permission to Liberty Speech Associates LLC, their employees, and/or their contractors to do the following (select all that apply):*

☐ I grant permission to provide me with written communication via unencrypted email service at the email address provided. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication via USPS to the address provided.

☐ I elect to receive clinical information in person.

☐ I grant permission to leave relevant clinical information on my answering machine or voicemail at the home phone number listed above.

☐ I grant permission to leave relevant clinical information on my answering machine or voicemail at the work phone number listed above.

☐ I grant permission to leave relevant clinical information on my answering machine or voicemail at the cell phone number listed above.

Appointment Information

For appointment information, such as appointment reminders, schedule changes, cancellations, etc., I hereby grant permission to Liberty Associates LLC, their employees, and/or their contractors to notify me by:* ☐Call ☐Text ☐Email

I understand that Liberty Speech Associates LLC, their employees, and/or their contractors will use the preferred contact method(s) chosen above for appointment and clinical information. I also understand that it is my responsibility to inform the practice of any changes to this information or to my communication preferences.

_____ _____

Name of Client* Today's Date*

_____

Signature of Client or Legal Representative*

_____ _____

Name of Legal Representative* Relationship to Client*

Insurance Form

Responsible Party:

Name:* _____ DOB:*_____ ▢M ▢F

Address:* _____

City/State:* _____ Zip: _____

Preferred Phone:* ( ) _____

Employer:* _____

Address: _____

City/State: _____ Zip: _____

Work Phone: ( ) _____

Insurance Information

Primary

Insurance Company Name:* _____

Insurance Phone Number: _____

Policy Holder Name:* _____

Policy Holder Date of Birth:* _____

Policy Holder SSN: _____

Member ID/Policy #:* _____

Group #: _____

Group Name: _____

Secondary

Insurance Company Name: _____

Insurance Phone Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder SSN: _____

Member ID/Policy #: _____

Group #: _____

Group Name: _____

Tertiary

Insurance Company Name: _____

Insurance Phone Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder SSN: _____

Member ID/Policy #: _____

Group #: _____

Group Name: _____

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) related to any and all health benefits due to my dependents and me.

If Liberty Speech Associates LLC is submitting claims on my behalf, I also authorize payment of healthcare benefits otherwise payable to me, directly to Liberty Speech Associates LLC. I agree to be held responsible for all charges and services not paid by my insurance company.

_____ _____

Name of Client* Today's Date*

_____

Signature of Client or Legal Representative*

_____ _____

Name of Legal Representative* Relationship to Client*

Acknowledgement of HIPAA Privacy Notice

Liberty Speech Associates LLC is required by law to keep your health information and records safe. This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

By signing below:
-I acknowledge that I have received a copy of Liberty Speech Associates LLC's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
-I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.
-I understand that Liberty Speech Associates LLC cannot disclose my health information other than as specified in the notice.
-I understand that Liberty Speech Associates LLC reserves the right to change the notice and the practices detailed therein if I receive a copy of the revised notice to the address I have provided.

_____ _____

Name of Client* Today's Date*

_____

Signature of Client or Legal Representative*

_____ _____

Name of Legal Representative* Relationship to Client*

HIPAA Policy
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment: We may use your protected health information to provide, coordinate, or manage health care and related services, by one or more health care providers. An example of this would include sending a copy of your therapy notes or evaluation to your physician.

Payment: We may use your protected health information for such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations: We may use your protected health information for the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- This notice is effective as of January 1, 2022 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775